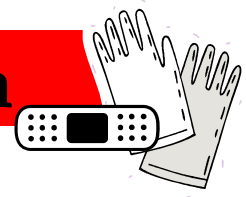




# Emergency Care Plan



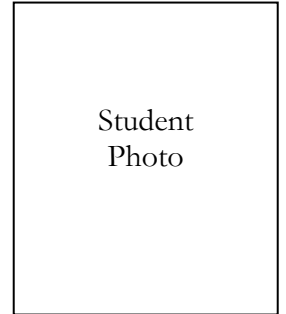
## LATEX ALLERGY

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Contact: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mother: \_\_\_\_\_ MHome #: \_\_\_\_\_ MWork #: \_\_\_\_\_ MCell #: \_\_\_\_\_  
 Father: \_\_\_\_\_ FHome #: \_\_\_\_\_ FWork #: \_\_\_\_\_ FCell #: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth
- **THROAT** Itching, tightness in throat, tightness in chest
- **SKIN** Hives, warmth, itchy rash, generalized swelling
- **STOMACH** Nausea, abdominal cramps, vomiting and/or diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

**The severity of symptoms can change quickly –  
it is important that treatment is give immediately.**



### STAFF MEMBERS INSTRUCTED:

- Administration       Classroom Teacher(s)       Special Area Teacher(s)  
 Support Staff       Transportation Staff

**TREATMENT:** Rinse contact area with water.

Benadryl ordered:  Yes  No Give \_\_\_\_\_ Benadryl per provider's orders

Call school nurse at \_\_\_\_\_. Call parent/guardian if off school grounds.

Epinephrine ordered:  Yes  No Special instructions: \_\_\_\_\_

**IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING ARE SEEN AT THE SITE AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.**

Preferred Hospital if transported: \_\_\_\_\_

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

**Transportation Plan:**  Medication available on bus     Medication NOT available on bus     Does not ride bus

Special instructions: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Written by: \_\_\_\_\_ Date: \_\_\_\_\_

- Copy provided to Parent       Copy sent to Healthcare Provider

**Parent/Guardian Signature** to share this plan with Provider and School Staff: \_\_\_\_\_

*This plan is in effect for the current school year and summer school as needed.*